



Information for Critical Access Hospitals



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What's Changed?

- Updated the critical access hospital (CAH) location relative to other facilities to include areas with only secondary roads available (page 5)
- CAHs must now inform the patient or their representative of their rights before starting or ending care and establish a grievance process (page 5)
- A CAH that's part of a health system with more than 1 hospital or CAH must now have a Quality Assessment and Performance Improvement Program to ensure it meets requirements (page 5)
- Clarified that under the optional payment method, the CAH bills facility and professional outpatient services only when the physicians or practitioners have reassigned their billing rights to them (page 9)
- Starting January 1, 2023, we developed a new provider type called rural emergency hospitals (REHs) (page 12)

You'll find substantive content updates in dark red.

Section 1820 of the [Social Security Act](#) establishes Medicare Rural Hospital Flexibility Programs (MRHFPs) that allow individual states to designate certain facilities as critical access hospitals (CAHs). A CAH is a separate provider type with its own Medicare [conditions of participation](#) (CoP) and separate payment methods, unlike Medicare dependent hospitals and sole community hospitals.

A rural hospital that provides limited services can become a CAH if it meets these conditions:

- Currently a Medicare-participating hospital
- A hospital that stopped operating after November 29, 1989
- A health clinic or center (according to the state definition) that operated as a hospital before downsizing to a health clinic or center

Together we can advance health equity and help eliminate health disparities in rural populations. Find these resources and more from the [CMS Office of Minority Health](#):

- [Rural Health](#)
- [Data Stratified by Geography \(Rural/Urban\)](#)
- [Health Equity Technical Assistance Program](#)

CAH Designations

A Medicare-participating hospital can become, and remain, a certified CAH by meeting these regulatory requirements*:

- Located in a state that established a state rural health plan for MRHFPs. Connecticut, Delaware, Maryland, New Jersey, and Rhode Island haven't established MRHFP state rural health plans.
- Located in a rural area or treated as rural under a special provision that qualifies hospital providers in urban areas. CAHs have a 2-year transition period to reclassify as rural if the Office of Management and Budget changes their location designation to urban. See [42 CFR 412.103](#) for more information.
- Provides 24-hour emergency services, 7 days a week, using on-site or on-call staff, with specific on-site, on-call staff response times.
- Doesn't exceed 25 inpatient beds for inpatient or swing bed services.
 - It may operate a distinct part rehabilitation and a psychiatric unit, each with up to 10 beds
 - If it has distinct part units (DPUs), it must follow all hospital and CAH CoPs in the DPU
- Reports an annual average acute care inpatient length of stay (LOS) of 96 hours or less (excluding swing bed services and DPU beds). We don't assess this requirement on initial certification; it only applies after CAH certification.

* This list contains basic requirements. It isn't all inclusive.

- Is **more than** a 35-mile drive **on primary roads** from any other CAH or hospital (or, **in the case of mountainous terrain or in areas with only secondary roads available**, a 15-mile drive) if a state didn't designate a CAH as a necessary provider before January 1, 2006. **A primary road of travel for determining the driving distance of a CAH and its proximity to other providers is a numbered federal highway, including interstates, intrastates, expressways, or any other numbered federal or state highways with 2 or more lanes each way.**

The CAH must inform each patient, or their representative, of their rights before starting or ending patient care. This requires CAHs to establish a process for overseeing and promptly resolving patient grievances, including whom to contact to file a grievance.

If the CAH is part of a health system with more than 1 hospital or CAH, it must have a unified and integrated Quality Assessment and Performance Improvement Program to ensure each of its separately certified CAHs meets requirements.

Hospice Care

In hospice care cases, a hospice may contract with a CAH to provide general inpatient hospice care. We pay the hospice in these cases.

You may dedicate beds to hospice care. The beds count toward the 25-bed maximum. However, hospice patients aren't part of the 96-hour annual average LOS calculation.

You can admit hospice patients to a CAH for any care in their hospice treatment plan or respite care. The CAH negotiates payment through an agreement with the hospice.

CAH Payments

- We pay CAHs for most inpatient and outpatient services provided to patients at 101% of reasonable costs
- We don't include CAHs in the hospital Inpatient Prospective Payment System (IPPS) or the hospital Outpatient Prospective Payment System (OPPS)
- We pay CAH services according to Part A and Part B [deductible and coinsurance](#) amounts
- CAHs aren't limited to the 20% CAH Part B outpatient copayment amount by the Part A inpatient deductible amount
- We encourage CAHs to help patients understand service charges and potential financial obligations

CAHs Participation in the Medicare Promoting Interoperability Programs

The American Recovery and Reinvestment Act of 2009 authorized incentive payments under Medicare as well as downward payment adjustments for the meaningful use of certified electronic health record technology. As of 2016, CAHs that don't successfully demonstrate meaningful use are subject of a reduction to their payments from 101% to 100% of reasonable costs. There are hardship exceptions available but, by law, a CAH is limited to 5 years of these exceptions.

CAH Distinct Part Units

- We pay for CAH DPU inpatient rehabilitation services under the Inpatient Rehabilitation Facility Prospective Payment System (PPS)
- We pay CAH DPU psychiatric services under the Inpatient Psychiatric Facility PPS

CAH Swing Beds

- We pay for CAH swing bed services (Section 1883(a)(3) of the [Social Security Act](#) and [42 CFR 413.114\(a\)\(2\)](#)).
- During the COVID-19 Public Health Emergency (PHE), we waive the limit on the number of swing beds.
- CAH swing bed services aren't subject to Skilled Nursing Facility (SNF) PPS. Instead, we pay CAHs based on 101% of reasonable costs.
- CAHs may bill for:
 - Bed and board, nursing, and other related services
 - Use of CAH facilities
 - Medical social services
 - Drugs
 - Biologicals
 - Supplies, appliances, and equipment for inpatient hospital care and treatment and diagnostic or therapeutic items or services they, or others, provide under arrangement

Inpatient Admissions

We pay CAHs under Part A when they meet these requirements:

- A physician or other qualified practitioner orders admission and certifies they expect the individual to be discharged or transferred to a hospital within 96 hours of CAH admission ([42 CFR 412.3](#) and [42 CFR 485.638\(a\)\(4\)\(iii\)](#)).
- An individual may remain a CAH inpatient for more than 96 hours. However, if a physician can't certify at admission that they expect the individual to be discharged or transferred to a hospital within 96 hours, we won't pay the CAH.

- A physician must complete certification, then sign and document it in a medical record no later than 1 day before submitting an inpatient services claim.
- We don't apply the 96-hour certification requirement to these services:
 - Time as CAH outpatient.
 - Time providing skilled nursing swing bed services.
 - Time in CAH DPU.

The 96-hour certification clock begins when a physician or other qualified practitioner admits the patient via a written order in the patient's medical record.

- Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Supplemental Medical Review Contractors (SMRCs) don't audit the CAH 96-hour certification requirement as a medical record high priority
- CAHs shouldn't expect to get 96-hour certification medical record requests from these contractors unless we or the contractors find:
 - Gaming evidence
 - Screening and revalidation provider compliance failure
 - Other medical review issues

Note: Although MACs, RACs, and SMRCs no longer make auditing the CAH 96-hour certification requirement a high priority, the CMS Regional Office Division of Survey and Certification (RO DSC), State Survey Agencies (SAs), and accrediting organizations will verify CAH CoP LOS compliance according to [42 CFR 485.620\(b\)](#), which states the CAH provides acute inpatient care for a period that doesn't exceed 96 hours per patient, on average, annually.

MACs determine 96-hour annual average LOS CoPs compliance and calculate the CAH's LOS based on patient census data. If a CAH exceeds the LOS limit, their MAC sends a report to the CMS RO DSC and provides a copy to the SA. The CMS RO requires CAHs develop and apply an acceptable correction plan or provide adequate information demonstrating compliance.

Note: During the COVID-19 PHE, we **waive** the 96-hour annual average LOS requirement.

Inpatient hospital services with 20 inpatient days or more cases **must** meet additional certification requirements ([42 CFR 424.13](#)).



Ambulance Transports

- We pay for CAH-provided ambulance services, and ambulance services provided by an entity the CAH owns and operates, based on 101% of reasonable costs if it's the only ambulance provider or supplier within a 35-mile drive of the CAH. The 35-mile drive requirement excludes ambulance providers or suppliers not legally authorized to provide ambulance services to transport to or from the CAH.
- If no ambulance provider or supplier is within a 35-mile drive of the CAH and the CAH owns and operates an entity providing ambulance services more than a 35-mile drive from the CAH, we base the entity's ambulance payment on 101% of reasonable costs if that entity is the closest ambulance provider or supplier to the CAH.

CAH Reasonable Cost Payment Principles That Don't Apply

CAH inpatient or outpatient services payments **aren't** subject to these reasonable cost principles:

- Lesser of cost or charges
- Reasonable compensation equivalent limits

We don't apply limits to CAH inpatient payments on hospital inpatient operating costs or the 1-day or 3-day pre-admission payment window provisions that apply to hospitals paid under the IPPS and OPFS.

We apply payment window provisions to outpatient services if a patient gets CAH outpatient services at a wholly owned or operated IPPS hospital and that hospital admits the patient either on the same day or within 3 days immediately following the day the patient got those outpatient services.

Outpatient Services: Standard Payment Method (Method I) or Optional Payment Method (Method II)

We pay for CAH outpatient facility services at 101% of reasonable costs (Section 1834(g)(1) of the [Social Security Act](#)).

Standard Payment Method: Reasonable Cost-Based Facility Services with MAC Professional Services Billing

We pay CAHs under the [standard payment method](#) unless they elect the [optional payment method](#).

Under the standard payment method, the physician or practitioner bills their outpatient professional medical services under the [Medicare Physician Fee Schedule \(PFS\)](#). We define outpatient professional medical services payment as physician- or other qualified practitioner-provided services.

Optional Payment Method: Reasonable Cost-Based Facility Services Plus 115% Professional Services Fee Schedule Payment

Note: Under the optional payment method, the CAH bills facility and professional outpatient services only when physicians or practitioners have reassigned their billing rights to them. Additionally, physicians and practitioners can't bill for professional services once they've reassigned their billing rights to the CAH.

CAHs may elect the optional payment method instead of the standard payment method (Section 1834(g)(2) of the [Social Security Act](#)). The CAH bills for facility and professional outpatient services **only** when physicians or practitioners reassign their billing rights to the CAH.

If a CAH elects this option, each physician or practitioner providing professional outpatient CAH services can choose to:

- Reassign their billing rights to the CAH and agree to the optional payment method. They must attest in writing they won't bill for professional CAH outpatient services.
- File MAC claims for their professional CAH outpatient services under the Medicare PFS.

For physicians or practitioners who elect the optional payment method, a CAH must forward a completed [Medicare Enrollment Application: Reassignment of Medicare Benefits \(CMS-855R\)](#) to their MAC and reassign their benefits. The CAH keeps the original form on file.

We don't make CAHs submit an annual payment election under the optional payment method, so when CAHs elect the optional payment method, it stays in effect until the CAH submits a termination request. If the CAH elects to end its optional payment method, it must submit a written request to its MAC at least 30 days before the start of the next cost reporting period. For more information, find your [MAC's website](#).

We base the CAH outpatient optional payment method services payment on the sum of these, after applicable deductions:

- **Facility services:** 101% of CAH reasonable costs
- **Physician professional services:** 115% of our PFS allowable amount
- **Non-physician practitioner professional services:** 115% of PFS amount we normally pay practitioner's professional services

Telehealth Services Payment

We pay for telehealth services at 80% of PFS when the distant site physician or other practitioner location is in a CAH electing the optional payment method and the physician or other practitioner reassigns their billing rights to the CAH.

Teaching Anesthesiologist Services Payment

When a teaching anesthesiologist's location is a CAH that elected the optional payment method and the anesthesiologist reassigns their billing rights, we pay 115% of PFS if the anesthesiologist is involved in 1 of these cases:

- Training a resident in a single anesthesia case
- 2 concurrent resident anesthesia cases
- Single resident anesthesia case concurrent to another case paid under the medically directed rate

You can qualify for payment by meeting these requirements:

- Teaching anesthesiologist (or different anesthesiologist in the same anesthesia group) is present during all critical or key portions of the anesthesia service or procedure
- Teaching anesthesiologist or an anesthesiologist they have an arrangement with is immediately available to provide anesthesia services during the entire service or procedure

Patient's medical record must document:

- Teaching anesthesiologist's presence during all critical or key portions of the anesthesia service or procedure
- Immediate availability of another teaching anesthesiologist as necessary

Report the NPI of the teaching anesthesiologist who started the case on the claim during critical or key procedure times and when different teaching anesthesiologists are with the resident.

Submit teaching anesthesiologist claims using these modifiers:

- **AA:** Anesthesia services personally performed by an anesthesiologist
- **GC:** Under a teaching physician, the resident performed part of the service

Additional Medicare Payments

Residents in Approved Medical Residency Training Programs Who Train at a CAH

CAHs can choose to incur residency training costs directly or function as a Medicare graduate medical education non-provider setting for payment purposes.

- If a CAH incurs residency training costs directly, we pay them 101% of reasonable costs for training the full-time equivalent (FTE) residents
- If a CAH functions as a non-provider site, a hospital can include the FTE residents' training at the CAH in its FTE resident count if it meets the non-provider site requirements ([42 CFR 412.105\(f\)\(1\)\(ii\)\(E\)](#) and [42 CFR 413.78\(g\)](#))

Medicare Certified Registered Nurse Anesthetist Services Rural Pass-Through Funding

- As incentive to continue serving the rural population, CAHs can get reasonable cost-based funding for certain certified registered nurse anesthetist (CRNA) services
- There are specific requirements rural hospitals and CAHs must meet to get Medicare rural pass-through funding ([42 CFR 412.113\(c\)](#))
- CAHs qualifying for CRNA pass-through funding can get reasonable cost-based inpatient and outpatient CRNA professional services payments whether they use the standard payment method or optional payment method
- If a CAH opts to include a CRNA in its optional payment method election, we pay for the CRNA's services based on 115% of the PFS, and the CAH gives up inpatient and outpatient CRNA pass-through delivered services payments



Health Professional Shortage Area Physician Bonus Program

- We pay physicians (including psychiatrists) a 10% outpatient professional services Health Professional Shortage Area (HPSA) bonus if they provide CAH care in a primary care or mental health HPSA, within a designated geographic area
- If you reassign your billing rights and the CAH elected the optional payment method, the CAH gets 115% of the applicable Medicare PFS amount multiplied by 110% based on all the quarter's processed claims

For more information, see the [Physician Bonuses](#) webpage and [Health Professional Shortage Area Physician Bonus Program](#) fact sheet.

Medicare Rural Hospital Flexibility Program State Grants

MRHFPs have 2 separate, complementary parts:

- We provide reasonable cost-based Medicare-certified CAH payments
- The Health Resources & Services Administration, through the Federal Office of Rural Health Policy, runs a state grant program supporting community-based rural organized systems of care development in participating states

To get funds under the grant program, states must apply for them and engage in rural health planning by developing and maintaining a state rural health plan that:

- Describes and supports CAH conversions
- Promotes emergency medical services (EMS) integration by linking CAHs to local EMS and their network partners
- Develops CAH [rural health networks](#)
- Develops and supports quality improvement initiatives
- Evaluates state programs within the national program goals framework

For more information, see the [Rural Hospital Programs](#) webpage.

Rural Emergency Hospitals

Starting January 1, 2023, we introduced a [new provider type](#) called rural emergency hospitals (REHs) to address rural hospital closures. REHs allow for emergency services, observation care, and additional medical and health outpatient services (if the REH elects to provide them) that don't exceed an annual per patient average of 24 hours.

REHs generally convert from either a CAH or a rural hospital (with no more than 50 beds) and don't provide acute care inpatient services, except for SNF services in a DPU. The facility may submit a [Medicare Enrollment Application: Institutional Providers \(CMS-855A\)](#) change of information application (rather than an initial enrollment application) to convert from a CAH to an REH.

Resources

- [Medicare Claims Processing Manual, Chapter 3 & Chapter 4](#)
- [Medicare Promoting Interoperability Program](#)
- [Quality Safety & Oversight General Information](#)
- [Report: Medicare Part B Overpaid and Beneficiaries Incurred Cost-Share Overcharges of Over \\$1 Million for the Same Professional Services](#)
- [State Operations Manual, Appendix W](#)
- [Swing Bed Providers](#)
- [Swing Bed Services](#)

Policy References



Social Security Act

- [1814\(a\)\(8\)](#)
- [1814\(l\)](#)
- [1820](#)
- [1834\(g\)](#)
- [1834\(l\)\(8\)](#)
- [1883\(a\)\(3\)](#)
- [1861\(v\)\(1\)\(A\)](#)



Code of Federal Regulations

- [42 CFR 410.152\(k\)](#)
- [42 CFR 412.3](#)
- [42 CFR 413.70](#)
- [42 CFR 413.114\(a\)](#)
- [42 CFR 424.15](#)



Helpful Websites

- [Critical Access Hospitals Center](#)
- [National Association of Rural Health Clinics](#)
- [National Rural Health Association](#)
- [Rural Health Clinics Center](#)
- [Rural Health Information Hub](#)

Regional Office Rural Health Coordinators

Get contact information for [CMS Regional Office Rural Health Coordinators](#) who offer technical, policy, and operational help on rural health issues.

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